ELSEVIER

Social Science & Medicine 66 (2008) 376–386

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Ethics policies on euthanasia in nursing homes: A survey in Flanders, Belgium

Joke Lemiengre[a,*], Bernadette Dierckx de Casterlé[b], Geert Verbeke[c], Katleen Van Craen[b], Paul Schotsmans[a], Chris Gastmans[a]

[a]*Center for Biomedical Ethics and Law, Katholieke Universiteit Leuven, Kapucijnenvoer 35, 3000 Leuven, Belgium*
[b]*Center for Health Services and Nursing Research, Katholieke Universiteit Leuven, Kapucijnenvoer 35, 3000 Leuven, Belgium*
[c]*Biostatistical Center, Katholieke Universiteit Leuven, Kapucijnenvoer 35, 3000 Leuven, Belgium*

Available online 8 November 2007

Abstract

In many European countries there is a public debate about the acceptability and regulation of euthanasia. In 2002, Belgium became the second country after the Netherlands to enact a law on euthanasia. Although euthanasia rarely occurs, the complexity of the clinical–ethical decision making surrounding euthanasia requests and the need for adequate support reported by caregivers, means that healthcare institutions increasingly need to consider how to responsibly handle euthanasia requests. The development of written ethics policies on euthanasia may be important to guarantee and maintain the quality of care for patients requesting euthanasia. The aim of this study was to determine the prevalence, development, position, and communication of written ethics policies on euthanasia in Flemish nursing homes. Data were obtained through a cross-sectional mail survey of general directors of all Catholic nursing homes in Flanders, Belgium. Of the 737 nursing homes invited to participate, 612 (83%) completed the questionnaire. Of these, only 15% had a written ethics policy on euthanasia. Presence of an ethics committee and membership of an umbrella organization were independent predictors of whether a nursing home had such a written ethics policy. The Act on Euthanasia and euthanasia guidelines advanced by professional organizations were the most frequent reasons (76% and 56%, respectively) and reference sources (92% and 64%, respectively) for developing ethics policies on euthanasia. Development of ethics policies occurred within a multidisciplinary context. In general, Flemish nursing homes applied the Act on Euthanasia restrictively by introducing palliative procedures in addition to legal due care criteria. The policy was communicated to the consulting general practitioner and nurses in 74% and 89% of nursing homes, respectively.

Although the overall prevalence of ethics policies on euthanasia was low in Flemish nursing homes, institution administrators displayed growing awareness of bearing responsibility for stimulating dialogue and reflection about how to deal with euthanasia requests within their institution.

Keywords: Belgium; Ethics policy; Euthanasia; Medical end-of-life decision making; Nursing homes; Palliative care

*Corresponding author. Tel.: +32 16 33 29 23.
E-mail addresses: Joke.Lemiengre@med.kuleuven.be (J. Lemiengre), Bernadette.DierckxdeCasterle@med.kuleuven.be (B. Dierckx de Casterlé), Geert.Verbeke@med.kuleuven.be (G. Verbeke), katleenvc@hotmail.com (K. Van Craen), Paul.Schotsmans@med.kuleuven.be (P. Schotsmans), Chris.Gastmans@med.kuleuven.be (C. Gastmans).

0277-9536/$ - see front matter
doi:10.1016/j.socscimed.2007.09.007

Introduction

In 2002, Belgium became the second country after the Netherlands to enact a law on euthanasia. This law allows euthanasia only under strict conditions and to be performed only by physicians (Belgian Ministry of Justice, 2002). Although the Belgian Act on Euthanasia mainly addresses the responsibilities of physicians, there is a growing awareness that healthcare institutions also bear significant responsibility in translating these legal regulations into optimal care for patients requesting euthanasia. The management of a healthcare institution is responsible for guaranteeing and maintaining quality care for its patients at the end of life, including those who request euthanasia. Physicians (Dobscha, Heintz, Press, & Ganzini, 2004; Stevens, 2006) and nurses (De Bal, Dierckx de Casterlé, De Beer, & Gastmans, 2006; van Bruchem–van de Scheur, van der Arend, Spreeuwenberg, van Wijmen, & ter Meulen, 2004) also need adequate support from managers when caring for patients who request euthanasia.

Processes within an organizational culture that may influence clinical–ethical decision making, such as the development of written ethics policies, are evoking increasing interest (Winkler, 2005). Thus far, nationwide research on prevalence, development, position, and communication of ethics policies on euthanasia in nursing homes has been carried out only in the Netherlands (Haverkate, Muller, Cappetti, Jonkers, & van der Wal, 2000; Haverkate & van der Wal, 1996, 1998). For Belgian nursing homes, data about ethics policies on euthanasia are available only for Flemish Catholic institutions, which represent 33% of all nursing homes in Flanders (Gastmans, Lemiengre, van der Wal, Schotsmans, & Dierckx de Casterlé, 2006). Prevalence of ethics policies on euthanasia varies: around 30% of Flemish Catholic nursing homes (Gastmans et al., 2006) and between 62% and 74% in Dutch nursing homes (Haverkate & van der Wal, 1998; Haverkate et al., 2000).

Legalization of euthanasia and the existence of an ethics committee are likely to affect the development of these policies (Gastmans et al., 2006; Haverkate & van der Wal, 1998; Haverkate et al., 2000). Also, the religious identity of the healthcare institution might affect its position regarding euthanasia (Gastmans et al., 2006; Haverkate & van der Wal, 1998).

In our pilot study (Gastmans et al., 2006) we surveyed only Catholic nursing homes, obtaining a moderate response rate of 62%. Thus, results from this study need to be interpreted cautiously and should not be generalized. The overall aim of the present study was to survey the prevalence, development, position, and communication of ethics policies on euthanasia in all Flemish nursing homes. In particular, we analyzed how nursing home characteristics (religious affiliation, existence of an ethics committee, etc.) influence the prevalence, development, and position of ethics policies on euthanasia.

Methods

Study population and data collection

We used a cross-sectional descriptive mail survey. The study was carried out from November 15, 2005, to February 28, 2006, in Flanders, the Dutch-speaking region of Belgium, where 60% (5.9 million) of the nation's population lives. Questionnaires were mailed to general directors of all nursing homes in Flanders ($n = 737$). We obtained the list of Flemish nursing homes from Flemish Ministry of Health databases, including addresses and institutional characteristics, such as type of institution (for residents requiring a low or high level of care), province, ownership (private vs public), and size (Flemish Ministry of Welfare, Health and Family, 2005). Six and 10 weeks after the first mailing, we mailed all non-responders a reminder together with a new questionnaire. After two reminders, non-responders were telephoned by one of two researchers (J.L., K.V.C.), kindly requesting their participation in our study.

Questionnaire: validity and reliability

The questionnaire was based on the one used in our pilot study (Gastmans et al., 2006), which in turn was based, in part, on a Dutch semi-structured questionnaire (Haverkate & van der Wal, 1996) which we adapted to the Belgian context. A three-step method was used to optimize its validity. First, we altered the questionnaire according to findings obtained through a thorough literature review (Lemiengre, Dierckx de Casterlé, Van Craen, Schotsmans, & Gastmans, 2007). Second, 12 experts[1] critiqued the relevance and clarity of each

[1]Eight ethicists with broad experience in ethics committees and/or ethics policy making, and four jurists. All experts had required knowledge about the euthanasia issue.

item of the adjusted questionnaire in a standardized way (Lynn, 1986). We made small adjustments based on their critiques. Lastly, the questionnaire was adapted according to the comments of six general directors to ensure that the questionnaire was clearly written and constructed for the targeted subjects of the study.

The revised questionnaire consisted of 20 questions, organized into five major parts. The first part contained general questions about nursing home characteristics (type, province/location, ownership, religious affiliation, size, existence of an ethics committee). The second part contained on the one hand questions on whether and in which year an ethics policy on euthanasia, withholding and/or withdrawing life-sustaining treatment, pain and symptom control with possible death hastening side effects, or palliative sedation have been developed, and contained on the other hand questions about the development of ethics policies on euthanasia (reasons, sources, parties involved). The third part contained questions about the stance toward euthanasia described in the policy. The fourth part contained questions about the communication of the policy to professional caregivers, patients, and relatives. The fifth part contained questions for hospitals without an ethics policy on euthanasia (reasons, future plans).

Definitions

According to Article 2 of the Belgian Act on Euthanasia, *euthanasia* is defined as the intentional termination of life by someone other than the person concerned, at the latter's request. 'Someone other' is understood to be a doctor, and 'terminating life' is interpreted as the administration of a lethal dose of medication (Belgian Ministry of Justice, 2002). According to the Belgian Act on Euthanasia, the physician commits no criminal offense if he fulfilled all conditions outlined by law (Art. 3.1) and if he respected the due care criteria detailed by this Act. These conditions and procedures differ when euthanasia is requested by competent persons (Art. 3.2), by persons no longer able to express their will (i.e., incompetent, Art. 4.2), and by persons clearly not expected to die imminently (i.e., not terminally ill, Art. 3.3, additional information: see Table 1, Belgian Ministry of Justice, 2002).

A *written ethics policy* is defined as written agreements (procedures, guidelines, protocols, etc.) authorized at the institutional level to guide caregivers when approaching a clinical–ethical problem that includes a decision-making process and/or phased plan (Haverkate & van der Wal, 1996).

Table 1
Belgian Act on Euthanasia: due care criteria

Requirements that have to be respected by the physician who performs euthanasia in case of competent terminally ill patients (Art 3.2), non-terminally ill patient (Art 3.3), and incompetent terminally ill patient (Art 4.2).
The physician must (Art 3.2):

- inform the patient about their condition of health and their life expectancy; discuss with the patient their request for euthanasia, and the possible therapeutic and palliative courses of actions and their consequences;
- be certain of the patient's constant physical or mental suffering and of the durable character of their request;
- consult another physician about the serious and incurable character of the disorder and inform them about the reasons for this consultation; inform the patient about the result of this consultation;
- discuss the request with the nursing team or its members;
- discuss the patient's request, if the patient so desires, with relatives appointed by the patient;
- be certain that the patient has had the opportunity to discuss his/her request with the persons that he/she wanted to meet.

If the physician believes the patient is clearly not expected to die in the near future, he/she must also (Article 3.3):

- consult a second physician, who is a psychiatrist or a specialist in the disorder in question, and inform him/her of the reasons for such a consultation;
- allow at least 1 month between the patient's written request and the Act of Euthanasia.

The physician who performs euthanasia in consequence of an advance directive must (Article 4.2):

- consult another physician about the irreversibility of the patient's medical condition and inform him/her about the reasons for this consultation;
- if there is a nursing team that has regular contact with the patient, discuss the content of the advance directive with that team or its members;
- if a person taken in confidence is designated in the advance directive, discuss the request with that person;
- if a person taken in confidence is designated in the advance directive, discuss the content of the advance directive with the relatives of the patient designated by the person taken in confidence.

Statistics

Data were analyzed in terms of percent frequency. Non-parametric measures of association

(Phi coefficient for 2×2 tables, Cramér coefficient for rxk tables) were used to describe associations between categorical variables (Siegel & Castellan, 1988).

For nursing home characteristics, we used the Chi Square test to assess whether differences between groups were statistically significant. For 2×2 tables and rxk tables, of which at least 20% of cells had expected frequencies less than 5, we used the Fisher exact test and Chi square, respectively, with exact calculation of the p-values. Multiple analyses (binary and multinomial logistic regression) were used to predict which nursing home characteristics were associated with the development of ethics policies on euthanasia; $p < 0.05$ was considered to be significant. All analyses were performed using SPSS, release 12.0 (SPSS Inc., Chicago, IL).

Ethical considerations

The Research Ethics Committee of the Katholieke Universiteit Leuven approved the study protocol. Anonymity of the respondents was guaranteed by destroying all identification data on the questionnaires. Returning the completed questionnaire counted as informed consent to participate in the study.

Results

Sample description

The study had an 83% response rate. Of 737 nursing homes, directors of 612 completed and returned the questionnaire, and directors of 28 explicitly refused to cooperate. We were unable to contact the directors of 97 nursing homes for telephone follow-up. Baseline characteristics of included nursing homes are presented in Table 2. Eighty-one percent of nursing homes provided care for residents requiring a high level of care, 67% were private, and 44% were medium sized (61–120 beds). Furthermore, 41% had a Catholic affiliation, and 31% were members of Caritas Flanders, an umbrella organization that assembles Catholic healthcare institutions in Flanders. A minority (15%) of nursing homes had an ethics committee. Of nursing homes with an ethics committee ($n = 94$), 99% provided care for residents requiring a high level of care, 84% were private, 71% had a Catholic affiliation, 64% were members of Caritas Flanders, and 82% were medium or large sized (>60 beds).

Table 2
Characteristics of nursing homes in the sample ($n = 612$) compared to those of the entire invited population ($N = 737$) of nursing homes in Flanders, Belgium

	Responding nursing homes (%)	Population (%)
Type		
Nursing homes for residents with low level of care	19.1	19.1
Nursing homes for residents with high level of care	80.9	80.9
Province		
Antwerp	27.1	25.4
Limburg	9.6	9.8
East Flanders	24.0	26.3
Flemish Brabant	16.8	15.5
West Flanders	22.4	23.1
Ownership		
Public	33.3	33.6
Private	66.7	66.4
Size		
Small (<60 beds)	35.8	36.8
Medium (61–120 beds)	43.8	42.9
Large (>121 beds)	20.4	20.4
Member of Caritas Flanders[a]		
Yes	31.0	31.5
No	69.0	68.5
Religious affiliation		
Catholic	40.9	[b]
Neutral	59.1	[b]
Availability of ethics committee		
Yes	15.4	[b]
No	84.6	[b]

[a]Umbrella organization that assembles Catholic healthcare institutions in Flanders.
[b]Information about religious affiliation and the availability of ethics committee are not known for all Flemish nursing homes.

We found some important statistical associations between subpopulations. The strongest association was between membership in Caritas Flanders and religious affiliation (Phi = 0.774, $p < 0.001$). Of institutions with a Catholic affiliation, 74% were members of Caritas Flanders. Membership of Caritas Flanders was moderately associated with ownership type (Phi = 0.467, $p = 0.001$): All nursing homes that were members of Caritas Flanders were private, and of private nursing homes, 46% were members of Caritas Flanders.

Prevalence

Based on self-reported data of this survey, we measured an increase in the prevalence of written ethics policies on medical end-of-life decisions (MELDs) in Flemish nursing homes over the last 4 years: Before 2002, <5% had ethics policies on MELDs. At the time of the survey, 15% had them for euthanasia, 26% for withholding and withdrawing life sustaining treatment, 16% for palliative sedation, and 14% for pain and symptom control (Fig. 1). Sixty-two percent ($n = 379$) of surveyed nursing homes did not have an ethics policy on any type of MELD. Of the 92 nursing homes with an ethics policy on euthanasia, 38%, 34%, and 5%, respectively, also had an ethics policy on one, two, or three other categories of MELDs. Of nursing homes with an ethics committee ($n = 94$), 45% had an ethics policy on euthanasia, 63% had a policy for withholding and/or withdrawing life sustaining treatment, 33% for pain and symptom control with possible death hastening effects, and 29% for palliative sedation.

We found significant associations between the presence of an ethics policy on euthanasia and nursing homes that were members of Caritas Flanders ($p<0.001$), homes with an Catholic affiliation ($p<0.001$), homes in which an ethics committee was set up ($p<0.001$), homes with more than 90 beds ($p<0.001$), homes providing care for residents requiring high levels of care ($p = 0.001$), and homes that were privately owned ($p = 0.020$). Backward binary logistic regression analyses yielded only two significant predictors of the existence of a written ethics policy on euthanasia: availability of an ethics committee (OR = 5.382; CI = 3.122–9.277; $p<0.001$) and membership in Caritas Flanders (OR = 4.379; CI = 1.498–12.798; $p = 0.007$).

The majority of nursing homes (85%) lacked a written ethics policy on euthanasia at the time of the

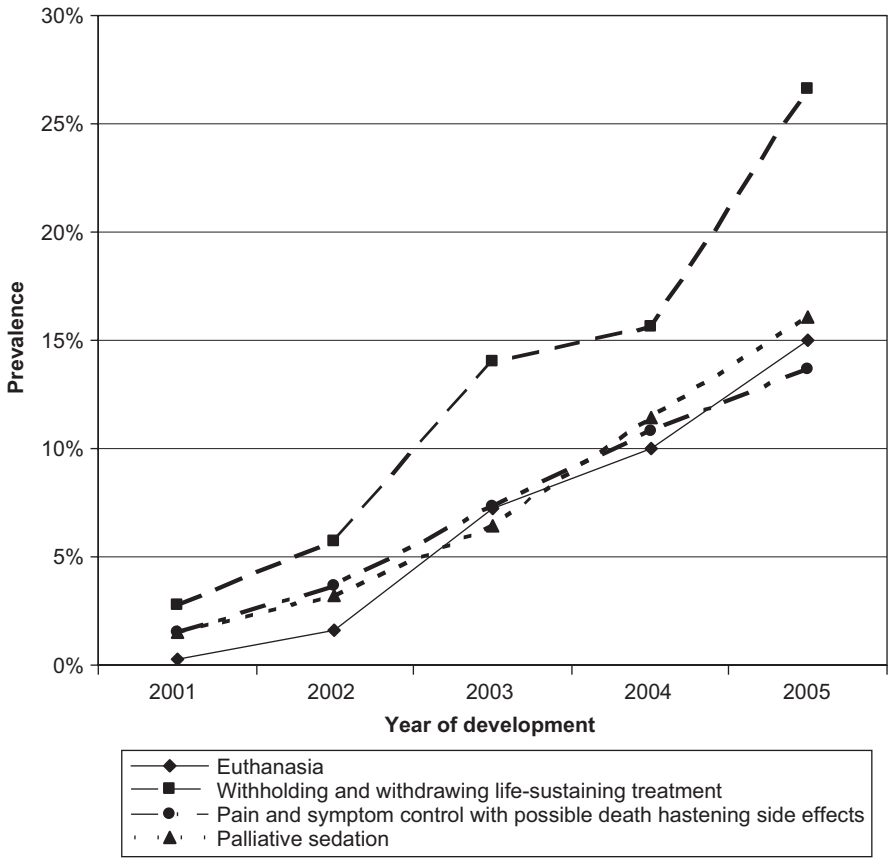

Fig. 1. Evolution of written ethics policies on euthanasia and other medical end-of-life decisions ($n = 612$). *Data based on self-report of nursing home directors.

survey. The most frequently reported reasons for not developing such policy was that they had not yet been confronted with euthanasia requests (60%), that in their opinion euthanasia was the responsibility of physicians (41%), and to a lesser extent, that the Act on Euthanasia was sufficient (13%). Of nursing homes without an ethics policy on euthanasia, 11% reported that they were in the process of drafting a policy, and 35% reported having plans to do so. The reasons given by directors of nursing homes with an ethics committee for not developing an ethics policy were similar to those described by directors of nursing homes without an ethics committee. The reasons that in their opinion euthanasia is the responsibility of the physician (47% vs 35%, $p<0.01$), that the Act on Euthanasia is sufficient (17% vs 8%, $p<0.01$), or that each euthanasia case is different (15% vs 8%, $p<0.05$) were more likely given by nursing homes without future plans to develop a policy in comparison with those with future plans.

Results of the multinomial regression analysis regarding the future plans of nursing homes are presented in Table 3. Backward multinomial logistic regression analysis yielded four significant predictors of homes that were in the process of and/or had plans to draft a written ethics policy on euthanasia: having an ethics committee, Catholic affiliation, large institutional size, and providing care for residents requiring high levels of care.

Development process

Table 4 presents a summary of the reasons for developing written ethics policies in Flemish nursing homes.

Approval of the Act on Euthanasia (2002) was the most frequently reported reason for developing a written ethics policy on euthanasia (76% of nursing homes). Other frequently reported reasons were the distribution of guidelines on euthanasia by professional organizations, passage of the Act on Palliative Care, and confrontation with euthanasia requests.

Most often, the development and approval of ethics policies on euthanasia took place in a multidisciplinary context: The consulting general practitioner (GP) (82%), the board of directors (80%), GPs (78%) were the most involved partners in the development process. In approving ethics policies on euthanasia, the daily managerial staff (82%), the board of directors (79%), and the consulting GP (70%) were the most involved partners. In 44% and 33% of nursing homes that had adopted ethics policies, the ethics committee was involved in either developing or approving the ethics policy on euthanasia.

Table 3
Multinomial regression analysis of future plans to develop ethics policies on euthanasia

Independent predictors of nursing homes	*p*	In the process of drafting a policy Odds ratio (95% CI)[a]	Have plans to draft a policy Odds ratio (95% CI)[a]
Availability of ethics committee	0.003		
Yes		4.166 (1.823–9.457)	1.325 (0.645–2.723)
No		1.000	1.000
Religious affiliation	0.000		
Catholic		2.975 (1.559–5.678)	1.976 (1.299–3.005)
Neutral		1.000	1.000
Size	0.002		
Large		4.421 (1.335–14.639)	1.918 (1.031–3.567)
Medium		3.768 (1.348–10.530)	0.886 (0.530–1.482)
Small		1.000	1.000
Type	0.038		
Providing care for residents requiring a high level of care		0.980 (0.281–3.413)	2.196 (1.180–4.086)
Providing care for residents requiring a low level of care		1.000	1.000

Abbreviations: CI, confidence interval.
[a]Reference category is the lack of plans to draft a policy in the future.

Table 4
Reasons, sources, and partners involved in developing written ethics policies on euthanasia[a]

	n (%)
Reasons for developing an ethics policy[b]	
Approval of Act on Euthanasia on May 28, 2002	68 (75.6)
Distribution of euthanasia guidelines from professional organizations	50 (55.6)
Approval of Act on Palliative Care on June 14, 2002	28 (31.1)
Confrontation with euthanasia requests	27 (30.0)
Upon request from daily management	11 (12.2)
Upon request from nurses	10 (11.1)
Upon request from general practitioners	8 (8.9)
Sources used in developing an ethics policy[b]	
Act on Euthanasia, May 28, 2002	83 (92.2)
Euthanasia guidelines from professional organizations	58 (64.4)
Policies of other nursing homes or hospitals	43 (47.8)
Scientific publications	41 (45.6)
Position papers in newspapers	29 (32.2)
Experiences of general practitioners	26 (28.9)
Experiences of nurses	26 (28.9)
Partners involved in developing an ethics policy[b]	
Consulting general practitioner	74 (82.2)
Daily managerial staff	72 (80.0)
General practioner(s)	70 (77.8)
Palliative experts	60 (66.7)
Board of directors	52 (57.8)
Ethics committee	40 (44.4)
Middle management	40 (44.4)
External experts	31 (34.4)
Partners involved in approving an ethics policy[b]	
Daily managerial staff	74 (82.2)
Board of directors	71 (78.9)
Consulting general practioner	63 (70.0)
Palliative experts	41 (45.6)
Ethics committee	30 (33.3)
Middle management	21 (23.3)
General practitioner(s)	15 (16.7)

[a]Percentages based on data from 90 nursing homes that completed and returned our questionnaire.
[b]Multiple answers were possible.

Position

Table 5 shows an overview of the position of Flemish nursing homes on euthanasia as expressed in written ethics policies.

In situations involving *competent, terminally ill patients*, 58% of nursing homes permitted euthanasia only in accordance with the law and in combination with additional palliative procedures. Thirty-four percent of nursing homes permitted euthanasia in accordance with the law without additional palliative procedures. Only 8% of nursing homes prohibited euthanasia, primarily for the reason that euthanasia was believed to conflict with the religious identity of the institution.

In situations involving *incompetent, terminally ill patients*, 52% of nursing homes prohibited euthanasia. Twenty-eight percent of nursing homes permitted euthanasia only in accordance with the law and in combination with additional palliative procedures, and 19% permitted euthanasia in accordance with the law without additional palliative procedures. Frequently reported reasons for prohibiting euthanasia were that euthanasia was believed to conflict with the religious identity of the institution (59%); belief that the Belgian Act on Euthanasia forbids euthanasia in the case of incompetent, terminally ill patients (57%); frequent problems interpreting advance directives (50%); and irreversibility of euthanasia (46%).

In the situations involving *non-terminally ill patients*, 47% of nursing homes prohibited euthanasia. Twenty-six percent of nursing homes permitted euthanasia in these cases only in accordance with the law and in combination with additional palliative procedures, and 27% permitted it in accordance with the law without additional palliative procedures. Frequently reported reasons for prohibiting euthanasia in these cases were that euthanasia was believed to conflict with the religious identity of the institution (69%); that therapeutic alternatives for non-terminally ill patients should be further investigated (54%); irreversibility of euthanasia (46%); and belief that the Belgian Act on Euthanasia forbids euthanasia in non-terminally ill patients (36%).

Nursing homes that had a Catholic affiliation, that were members of Caritas Flanders, or that had an ethics committee were more restrictive toward euthanasia (i.e., euthanasia is not permitted, or is permitted after legal due care criteria have been met and after additional palliative procedures have been exhausted. By contrast, public nursing homes were more likely to be less restrictive toward euthanasia.

Communication

In the majority of nursing homes, general directors took the initiative to communicate their ethics policies on euthanasia spontaneously to nurses (89%), other caregivers (84%), the consulting GP (74%), and GPs (36%). Ethics policies were communicated through informative meetings

Table 5
Position on euthanasia as expressed in written ethics policies[a]

	Euthanasia is not permitted, *n* (%)	Euthanasia is permitted in accordance with the law and additional palliative procedures, *n* (%)	Euthanasia is permitted in accordance with the law, *n* (%)	*p*
In competent, terminally ill patients				
General	7 (7.9)	52 (58.4)	30 (33.7)	
Member of Caritas Flanders	5 (10.0)	43 (86.0)	2 (4.0)	0.000
Public	1 (4.8)	4 (19.0)	16 (76.2)	0.000
Catholic affiliation	5 (9.8)	44 (86.3)	2 (3.9)	0.000
Availability of ethics committee	2 (4.9)	27 (65.9)	12 (29.3)	0.486
In incompetent, terminally ill patients				
General	46 (52.3)	25 (28.4)	17 (19.3)	
Member of Caritas Flanders	36 (72.0)	13 (26.0)	1 (2.0)	0.000
Public	5 (23.8)	9 (42.9)	7 (33.3)	0.010
Catholic affiliation	36 (72.0)	13 (26.0)	1 (2.0)	0.000
Availability of ethics committee	25 (61.0)	6 (14.6)	10 (24.4)	0.026
In non-terminally ill patients				
General	42 (47.2)	23 (25.8)	24 (27.0)	
Member of Caritas Flanders	35 (70.0)	11 (22.0)	4 (8.0)	0.000
Public	3 (14.3)	2 (9.5)	16 (76.2)	0.000
Catholic affiliation	36 (70.6)	11 (21.6)	4 (7.8)	0.000
Availability of ethics committee	23 (56.1)	14 (34.1)	4 (9.8)	0.003

[a]Percentages based on data from 89 nursing homes that completed and returned our questionnaire, for competent terminally ill patients and non-terminally ill patients; and on data from 88 nursing homes that completed and returned our questionnaire for incompetent terminally ill patients.

(39–93%) and by dissemination of a copy of the policy (36–64%). Fifty percent and 66% of nursing homes communicated their ethics policies to both residents and residents' relatives, respectively, upon their request. The most common methods of communicating ethics policies were oral information (46–50%) and dissemination of an information brochure about the policies (33–34%).

Discussion

In many European countries, a public debate is ongoing about the acceptability and regulation of euthanasia and other MELDs (Alfandari & Pedrot, 2005; Branthwaite, 2005; Cohen, Marcoux, Bilsen, Deboosere, van der Wal, & Deliens, 2006; Finlay, Wheatley, & Izdebski, 2005; Höfling, 2006). Over the last 4 years, since the Belgian Act on Euthanasia came into force in 2002, an increase in ethics policies on euthanasia and policies on other MELDs in Flemish nursing homes is observed. Despite this increase, the overall prevalence of ethics policies on euthanasia remains low (15%) in 2006. Yet, although the number of actual performed euthanasia cases in Belgian nursing homes—5% of all registered cases of euthanasia between January 2004 and December 2005 (Federal Control and Evaluation Committee on Euthanasia, 2006)—remains limited, euthanasia requests and the decision making processes following these requests are expected to occur more frequently in the near future.

Although the number of euthanasia cases is also small in Dutch nursing homes, the prevalence of ethics policies on euthanasia in Dutch nursing homes, by contrast, is much higher (62–74%) (Haverkate et al., 2000; Haverkate & van der Wal,

1996, 1998). This may be explained by cultural and organizational differences between Flemish and Dutch nursing homes. *First,* in comparison with the Netherlands, the Belgian debate on euthanasia is a more recent development. In the Netherlands, the euthanasia law is generally considered the codification of the norms and procedures that have governed the practice of euthanasia in the Netherlands for almost three decades. Hence, Dutch hospitals have been sensitized for a longer period about developing euthanasia policies. In Belgium, there is no relevant jurisprudence and no guidance has been offered through self-regulation by the medical profession itself before or after the enactment of the Act on Euthanasia in 2002 (Nys, 2002). *Second*, in the Netherlands, several organizations, e.g. Dutch State Commission on Euthanasia, have pointed out the importance of having an institutional policy on euthanasia (Haverkate, 1999). *Third*, the different profile of the Flemish consulting GP may also contribute to the lower prevalence of euthanasia policies in Flemish nursing homes. In Belgium, each resident keeps his or her own GP, and each nursing home has a consulting GP who is responsible for facilitating the cooperation between both nursing home management and other GPs. Flemish nursing homes have a non-medical culture and organization that emphasizes care and the well-being of residents. Therefore, the resident's GPs are not included in the organizational structure. The consulting GP is part of the organizational structure, but is not employed by the nursing home and his task does not constitute a full-time occupation. The resident's GP deals with the euthanasia request and bears the final responsibility in euthanasia decision-making. The consulting GP will be involved in nursing home policymaking, can function as the 'second physician' for giving advice to the resident's GP and can be consulted in case of conflicts or issues concerning the euthanasia request. Conversely, Dutch nursing home physicians are part of the organizational structure of the nursing home, a fact that may facilitate euthanasia policy development.

Legislation likely affected the tendency to develop written ethics policies in nursing homes. Before 2002, less than 5% of ethics policies were developed, while after 2002, an increase in policies of all MELDs was observed. Furthermore, 46% of nursing homes without a euthanasia policy reported to be in the process of developing one or had plans to develop such policy. In this way, the Belgian Act on Euthanasia may have been an incentive to develop ethics policies in Flemish nursing homes. In addition, nursing homes with an ethics policy on euthanasia reported the Act to be both reason and source for policy development. A similar trend apparently accounts for the development of do-not-resuscitate (DNR) policies in the USA. After the Patient Self-Determination Act became law in the USA in 1991, the prevalence of DNR policies increased significantly in American nursing homes (Lemiengre et al., 2007).

Multidisciplinary cooperation between nursing home administrators, GPs, palliative experts, and ethics committees occurred during the development of ethics policies. However, these findings need some comment. To arrive at a qualitative policymaking process, input from experts and deliberation in a community of equals are needed (Winkler, 2005). Yet, ethics committees and palliative experts were not involved in policymaking in 55% and 33% of nursing homes, respectively. Furthermore, next to the great involvement of nursing home management and GPs in policymaking, the role of bedside nurses was not reported. Giving bedside nurses a voice in policy development is necessary to recognize them as moral agents and to facilitate policy implementation (Winkler, 2005).

Next to the membership in an umbrella organization such as Caritas Flanders, the existence of an ethics committee was identified as an important supporting factor in the development of euthanasia policies. Our findings showed a clear association between 'having a policy' and 'having an ethics committee,' which is in agreement with earlier research (Lemiengre et al., 2007). However, only 15% of Flemish nursing homes actually had an ethics committee. The setup of ethics committees in Flemish nursing homes is a new development, which can explain this low prevalence. Additionally, while it is legally imperative for Flemish *hospitals* to have an ethics committee, there are no legal regulations and no financial support for ethics committees in Flemish *nursing homes*. Yet, not all nursing homes with an ethics committee had an ethics policy. A possible explanation for this is that 'new' or 'young' ethics committees need to put energy in self-education in order to gather knowledge and expertise first, so that only in a next phase, policies can be developed (Thompson & Thompson, 1990). Another role of ethics committees may be to create an 'ethics think tank' as a moral space for reflection in which the desire to explore the issue fully and

fairly, rather than the strategic interests of the institution, dominates the deliberation process (Winkler, 2005). Furthermore, through facilitating dialogue and education within the institution, ethics committees can stimulate reflection on how to deal with euthanasia requests within the institution. In this way, ethics committees can do more than 'just develop policies' and be more than a bureaucratic solution for ethical problems in the nursing home (Chambliss, 1988).

Flemish nursing homes generally reported adopting a restrictive application of the Act on Euthanasia by introducing the 'palliative filter procedure.' Thus, most Flemish nursing homes regard the mere application of due care criteria outlined in the law as insufficient to justify euthanasia. When using the palliative filter, euthanasia can only be considered as 'case of necessity' or as 'casus perplexus.' The palliative filter is a Flemish concept, introduced by the Flemish Palliative Care Federation (Broeckaert & Janssens, 2002), and integrated in the practice guideline of Caritas Flanders ''Caring for a dignified end of life'' (Gastmans, 2005). Both organizations played an important role in disseminating the palliative filter procedure. The objective of this procedure is to ensure that all pertinent caregivers inform one another about a euthanasia request and about all palliative care alternatives (Broeckaert & Janssens, 2002; Gastmans, 2005).

In particular in the case of incompetent, terminally ill (via advance directives) and non-terminally ill patients, Flemish nursing homes applied the Act on Euthanasia restrictively by introducing palliative procedures in addition to legal due care criteria, or by not allowing euthanasia at all. However, according to the Belgian Act on Euthanasia (2002), under certain conditions euthanasia is also allowed in these patients. We also observed this restrictiveness in our pilot study (Gastmans et al., 2006). Catholic nursing homes were more likely to be restrictive, a finding also reported by Haverkate and van der Wal (1998). By using the palliative filter, Catholic nursing homes may have found a way to preserve their Catholic identity within the pluralistic Belgian society. Generally, public nursing homes were more likely to regard the mere application of due care criteria outlined in the law, without further restrictions, as sufficient to justify euthanasia. A complete prohibition of euthanasia was rather rare in public nursing homes and the palliative filter was less used compared with Catholic nursing homes. This means that the majority of public nursing homes did not consider the consultation of a palliative expert a necessity in case of a euthanasia request. As public nursing homes were not members of Caritas Flanders, the Caritas Flanders guideline may have had less influence in public nursing homes (Gastmans, 2005).

Organizations actively promoting palliative care played an active role in the Belgian euthanasia debate. The Belgian euthanasia debate itself functioned as a lever in that it facilitated further development of palliative care, as illustrated by the Act on Palliative Care that was approved at the same time as the Act on Euthanasia. Because of a very fruitful cooperation between palliative care organizations and the Belgian authorities, a unique, comprehensive, legal, and organizational palliative care framework was set up nationwide (Gastmans, Van Neste, & Schotsmans, 2004) which makes the implementation of the palliative filter more plausible in clinical practice. To our knowledge, no data is available about the use of the palliative filter procedure in the Netherlands.

Conclusion

This survey was the first nation-wide study about ethics policies in nursing homes in Flanders and had a high response rate. A low prevalence of euthanasia policies was reported. However, an increase in prevalence is expected in the near future. Although the overall prevalence of ethics policies on euthanasia was low in Flemish nursing homes, institution administrators displayed growing awareness of bearing significant responsibility for stimulating dialogue and reflection about how to deal with euthanasia requests within their institution.

Providing a high standard of care for patients requesting euthanasia certainly requires more than the development of ethics policies. The ways in which ethics policies on euthanasia are developed and implemented will be crucial to obtain policies that really stimulate dialogue and ethical reflection about euthanasia within the institution. Therefore, additional research, both quantitative and qualitative, is needed to understand and analyze the processes that accompany policy implementation in order to optimize these processes. Furthermore, the degree to which ethics policies actually contribute to the support of physicians and nurses dealing with euthanasia requests is an essential track for future research.

Acknowledgments

The authors wish to acknowledge Catherine Guisson, who provided substantial support for the data collection of this study. The authors gratefully thank all nursing home directors for participating in this study. The study was made possible by a grant from the Fonds Voor Wetenschappelijk Onderzoek Vlaanderen.

References

Alfandari, E., & Pedrot, P. (2005). La fin de vie et la loi du 22 avril 2005. *Revue de droit sanitaire et social*, *5*, 751–765 [End of life and the Act of April 22, 2005].

Belgian Ministry of Justice. (2002). Wet betreffende de euthanasie. Belgian Law Gazette of June 22 [The Belgian Act on Euthanasia].

Branthwaite, M. A. (2005). Time for change. *British Medical Journal*, *331*, 680–683.

Broeckaert, B., & Janssens, R. (2002). Palliative care and euthanasia: Belgian and Dutch perspectives. *Ethical Perspectives*, *9*, 156–175.

Chambliss, D. F. (1988). *Beyond caring: Hospitals, nurses and the social organization of ethics*. Chicago/London: The University of Chicago Press.

Cohen, J., Marcoux, I., Bilsen, J., Deboosere, P., van der Wal, G., & Deliens, L. (2006). European public acceptance of euthanasia: Socio-demographic and cultural factors associated with the acceptance of euthanasia in 33 European countries. *Social Science & Medicine*, *63*, 743–756.

De Bal, N., Dierckx de Casterlé, B., De Beer, T., & Gastmans, C. (2006). Involvement of nurses in caring for patients requesting euthanasia in Flanders (Belgium): A qualitative study. *International Journal of Nursing Studies*, *43*, 589–599.

Dobscha, S. K., Heintz, R. T., Press, N., & Ganzini, L. (2004). Oregon physicians' responses to requests for assisted suicide: A qualitative study. *Journal of Palliative Medicine*, *7*, 451–461.

Federal Control and Evaluation Committee on Euthanasia. (2006). *Tweede verslag voor de Wetgevende Kamers, 1 January 2004–31 December 2005, Brussels* [Second report to the Constitutive Chamber, 1 January 2004–31 December 2005].

Finlay, I. G., Wheatley, V. J., & Izdebski, C. (2005). The house of lords select committee on the assisted dying for the terminally ill bill: Implications for specialist palliative care. *Palliative Medicine*, *19*, 444–453.

Flemish Ministry of Welfare, Health and Family. (2005) Retrieved July 17, 2006, from 〈http://www.wvc.vlaanderen.be/welzijnengezondheid/zorgaanbod/index.htm〉.

Gastmans, C. (2005). Caring for a dignified end of life in a Christian health-care institution: The view of Caritas Catholica Vlaanderen. In P. Schotsmans, & T. Meulenbergs (Eds.), *Euthanasia and palliative care in the low countries* (pp. 205–226). Leuven/Paris/Dudley, MA: Peeters.

Gastmans, C., Lemiengre, J., van der Wal, G., Schotsmans, P., & Dierckx de Casterlé, B. (2006). Prevalence and content of written ethics policies on euthanasia in Catholic healthcare institutions in Belgium (Flanders). *Health Policy*, *76*, 169–178.

Gastmans, C., Van Neste, F., & Schotsmans, P. (2004). Facing requests for euthanasia: A clinical practice guideline. *Journal of Medical Ethics*, *30*, 212–217.

Haverkate, I. (1999). *Policies and guidelines on medical decisions concerning the end of life in Dutch health care*. Thela Thesis, Amsterdam.

Haverkate, I., Muller, M. T., Cappetti, M., Jonkers, F. J., & van der Wal, G. (2000). Prevalence and content analysis of guidelines on handling requests for euthanasia or assisted suicide in Dutch nursing homes. *Archives of Internal Medicine*, *160*, 317–322.

Haverkate, I., & van der Wal, G. (1996). Policies on medical decisions concerning the end of life in Dutch health care institutions. *JAMA: The Journal of the American Medical Association*, *275*, 435–439.

Haverkate, I., & van der Wal, G. (1998). Dutch nursing home policies and guidelines on physician-assisted death and decisions to forego treatment. *Public Health*, *112*, 419–423.

Höfling, W. (2006). Gesetz zur Sicherung der Autonomie and Integrität von Patienten am Lebensende. *Medizinrecht*, *24*, 25–32 [Act on the guarantee of the autonomy and integrity of patients at the end of life].

Lemiengre, J., Dierckx de Casterlé, B., Van Craen, K., Schotsmans, P., & Gastmans, C. (2007). Written ethics policies on end-of-life care: A literature review. Health Policy.

Lynn, M. R. (1986). Determination and quantification of content validity. *Nursing Research*, *35*, 382–385.

Nys, H. (2002). Euthanasia in the low countries: A comparative analysis of the law regarding euthanasia in Belgium and the Netherlands. *Ethical Perspectives*, *9*, 73–85.

Siegel, S., & Castellan, N., Jr. (1988). *Nonparametric statistics for the behavioral sciences*. New York: McGraw-Hill International Editions.

SPSS, Inc., Chicago, IL.

Stevens, K. E. (2006). Emotional and psychological effects of physician-assisted suicide and euthanasia on participating physicians. *Issues in Law and Medicine*, *21*, 187–200.

Thompson, M. A., & Thompson, J. M. (1990). Ethics committees in nursing homes: A qualitative research study. *HEC Forum*, *2*, 315–327.

van Bruchem–van de Scheur, A., van der Arend, A., Spreeuwenberg, C., van Wijmen, F., & ter Meulen, R. (2004). *De rol van verpleegkundigen bij medische beslissingen rond het levenseinde: Verslag van een landelijk onderzoek naar betrokkenheid en praktijken*. Utrecht: De Tijdstroom [Role of nurses in medical end-of-life decisions: Report of a nationwide study of involvement and practices].

Winkler, E. C. (2005). The ethics of policy writing: How should hospitals deal with moral disagreement about controversial medical practices? *Journal of Medical Ethics*, *31*, 559–566.